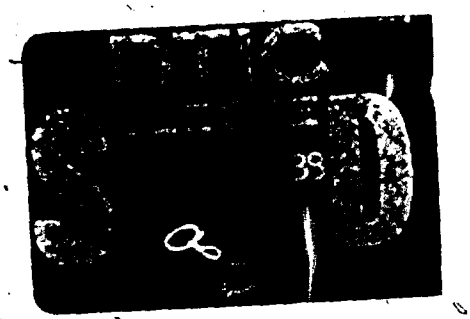
GAO

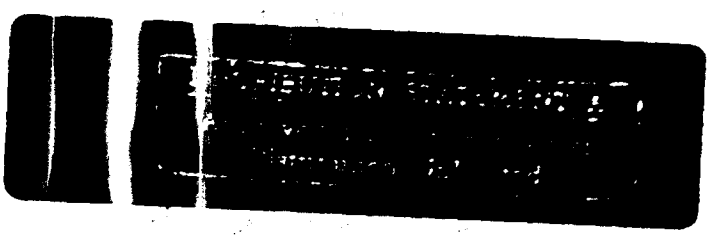
Report to the Chairman, Committee on Finance, U.S. Senate

February 1989

HEALTH INSURANCE

An Overview of the Working Uninsured





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Human Resources Division

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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

This report responds to your March 20, 1987, request concerning Americans with no health insurance. As agreed with your office, in this report we focus on providing information on the working uninsured, pointing out gaps and limitations in that information. Specifically, we discuss the characteristics of the working uninsured, the kinds of employers that do not offer health insurance, and the reasons these employers give for not providing it. We also discuss where the uninsured obtain medical care, the types of bills they incur, and who pays those bills. Finally, we outline the policy options available for providing health insurance to the working uninsured.

This report is one of a GAO series on the uninsured. The first report, Health Insurance: Risk Pools for the Medically Uninsurable, requested by the Senate Labor and Human Resources Committee, discussed state-sponsored risk pools for the medically uninsurable—their characteristics, enrollments, financial performance, and the degree to which they have met expectations. A second report, Health Insurance: A Profile of the Uninsured in Ohio and the Nation, requested by Senator Howard Metzenbaum of Ohio, discusses the characteristics of the uninsured and contains GAO's analysis of data from the Bureau of the Census's Current Population Survey. A forthcoming report, for the Senate Labor and Human Resources Committee, will provide information about selected insurers' underwriting practices and retention rates for small groups.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will make copies available to interested parties. The major contributors to this report are listed in appendix I.

Sincerely yours,

Michael Zimmerman
Director, Medicare and Medicaid Issues

Executive Summary

Purpose

Almost 37 million Americans were without health insurance in 1985. Of these Americans, at least two-thirds who were under the age of 65 were working adults and their uninsured dependents. Reduced availability of health insurance through employment contributed to the growth in the number of uninsured between 1982 and 1985.

Concerned about this problem, the Chairman of the Senate Finance Committee requested that GAO provide information on the working uninsured: their characteristics and those of their employers; the delivery of and payment for their health care; and the policy options available for providing health insurance to them. GAO also provided information on the gaps and limitations in existing data that may make it difficult for policymakers to design comprehensive solutions to reduce the number of working uninsured. This report is one of a series on the uninsured.

Background

Unlike other Western nations, which sponsor health benefits through public programs, Americans obtain their health benefits primarily through their source of employment—either employer- sponsored or union-sponsored health insurance. Only about 11 percent of Americans under the age of 65 are covered by public insurance such as Medicaid or Medicare; about 64 percent have employment-related insurance.

The percentage of Americans covered by employment-related health insurance has been declining, however, despite recent increases in the number of people working. Much of the recent growth in employment has been in industries and occupations where health benefits frequently are not sponsored. The number of working uninsured grew 22 percent between 1982 and 1985. In 1985, almost three-fourths of the uninsured who were of employment age worked at some time during the year, typically in low-wage or part-time jobs.

GAO evaluated data from 12 national databases and over 200 research studies to obtain information on the working uninsured; GAO also interviewed health policy analysts who were experts in the field. Through these discussions and its own analysis, GAO identified gaps in the existing research; therefore, GAO presents its own views on where additional research may be needed.

Results in Brief

Generally, the businesses least likely to offer health benefits are those that provide low-wage or low skill employment opportunities, such as service industries and retail trade; businesses with fewer than 100

employees; new businesses; and businesses in the southern and western regions of the United States (see pp. 23, 24, and 25). In recent public and private surveys, businesses most frequently cited insufficient profits and high insurance costs as reasons for not offering health insurance to their employees (see p. 26). In one business organization's opinion, if health insurance premiums were lowered through cost-containment efforts, greater coverage would be provided.

Options proposed to provide health insurance for the uninsured include mandating employer-sponsored health insurance; expanding Medicaid eligibility; establishing industry pooling mechanisms; and providing catastrophic coverage to all Americans (see pp. 43, 45, and 48). These options have limitations, such as covering some but not all of the uninsured. Furthermore, many questions remain about the costs or economic consequences of implementing these options.

Principal Findings

Data Are Limited on Working Uninsured

Available data indicate that the working uninsured are a heterogeneous group. Although their economic and demographic characteristics are known to some extent, the reasons for their lack of insurance remain largely unknown; the data on how they obtain health care and the number of services they obtain also remain largely unknown. Likewise, although much is known about the characteristics of the businesses the uninsured work for, limited data are available on why these businesses do not offer health insurance. Policymakers may find it difficult to design programs to reduce the number of working uninsured because of the combination of (1) limited data, (2) the diversity of the working uninsured population, and (3) a lack of knowledge about the reasons workers do not have health insurance.

Fewer Services Used by Uninsured

Compared with the poor insured, the poor uninsured generally use fewer services (for example, prescription drugs and physician visits), receive more free care, and use public hospitals as a regular source of care more often (see p. 34). Whether these uninsured use fewer services because they are in better health or because they cannot pay for services has not been definitively established. A recent national study, however, reported that financial barriers were the primary reason survey respondents had difficulty getting health care (see p. 35).

The medical bills incurred by the uninsured most often are for maternity cases and accidents (see p. 36). A study by the California Association of Public Hospitals indicated that the uninsured typically experience more complex and acute health problems; consequently, when they do receive health care, they often require multiple medical treatments and more intense services (see p. 37).

Payment of Services for Uninsured Varies

Health care services provided to the uninsured are paid for through a variety of sources (see pp. 38-40). Federal, state, and local funds provide support for indigent patients (that is, low-income people who are, nevertheless, ineligible for public assistance). Philanthropy, in both public and private hospitals, helps to cover some uncompensated care costs. In addition, hospitals frequently attempt to increase their charges to paying patients to cover their bad debt and charity care. Although data show that the uninsured have lower total health expenditures, their out-of-pocket costs are higher than those of the insured (see p. 39).

Recommendations

This report contains no recommendations.

Agency Comments

GAO made copies of the draft report available to the National Federation of Independent Business, the ERISA (Employee Retirement Income Security Act) Industry Committee, and Lewin and Associates, Inc. Their comments were included, as appropriate.

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Abbreviations

AFDC	Aid to Families With Dependent Children
AHA	American Hospital Association
BLS	Bureau of Labor Statistics
CBO	Congressional Budget Office
CCHP	Consumer Choice Health Plan
COBRA	Consolidate ! Omnibus Budget Reconciliation Act
CPS	Current Population Survey
CRS	Congressional Research Service
EBRI	Employee Benefit Research Institute
ERISA	Employee Retirement Income Security Act
GAO	General Accounting Office
HMO	health maintenance organization
MET	multiple employer trust
NCHSR	National Center for Health Services Research
NFIB	National Federation of Independent Business
NMCES	National Medical Care Expenditures Survey
NMES	National Medical Expenditures Survey
SBA	Small Business Administration
SIPP	Survey of Income and Program Participation
SSI	Supplemental Security Income

Introduction

Almost 37 million Americans were without health insurance in 1985, according to our analysis of the Census Bureau's March 1986 Current Population Survey (CPS).[1] At least two-thirds of the nonelderly (under the age of 65) uninsured are working adults and their uninsured dependents, and the number of this group of uninsured seems to be increasing.

The Chairman of the Senate Committee on Finance asked us to provide information on the working uninsured: their characteristics and those of their employers; where these uninsured obtain health care and who pays; and the policy options available for providing them with health insurance.

Most Health Insurance Is Employer-Sponsored

Employer-sponsored health insurance has become increasingly commonplace since World War II, with about 64 percent of the population being covered by employer-sponsored or union-sponsored health insurance in 1985. By contrast, only 7 percent of the population purchased an individual plan that year (see table 1.1).[2] After paid vacations, health insurance is the most common benefit offered by employers. As a result, employees in the United States have grown to rely on employers for health insurance. This is in contrast to most other Western nations where health benefits are sponsored through public programs.

[1] Health Insurance: A Profile of the Uninsured in Ohio and the Nation (GAO/HRD-88-83, Aug. 30, 1988).

[2] In two earlier reports, GAO studied the availability of individual health insurance: Health Insurance: Comparing Blue Cross and Blue Shield Plans With Commercial Insurers (GAO/HRD-86-110, July 11, 1986) examines differences in the provision of health insurance to high-risk individuals. Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 13, 1988) provides data on risk pools operated by six states—their characteristics and success in meeting expectations.

Table 1.1: Sources of Health Insurance for the Population Under the Age of 65 in the United States (1982 and 1985)

Population in thousands

Source of insurance	1982 Population	1982 Percent	1985 Population	1985 Percent
Private insurance				
Employer-sponsored or union-sponsored	133,613	65 5	134,570	64 3
Individual plan	16,123	7 9	15,370	7 3
Public insurance (federal)				
Medicaid	13,490	6 6	14,250	6 8
Medicare	2,499	1 2	2,510	1 2
CHAMPUS, Veterans Administration, and military health[a]	5,454	2 7	5,820	2 8
Subtotal	**171,179**	**83.9**	**172,520**	**82.4**
No insurance coverage	32,671	16.0	36,900	17 6
Total	**203,849[c]**	**100.0[c]**	**209,420**	**100.0**

[a]Civilian Health and Medical Program of the Uniformed Services

[b]Armed Forces members and their dependents living in off-base housing or on-base military housing

[c]Figures do not add because of rounding

Source: CPS, Bureau of the Census, March 1983 and March 1986

Number of Uninsured Is Increasing

According to a Congressional Research Service (CRS) analysis of CPS data, the number of uninsured Americans (both working and nonworking) under the age of 65 increased from 28.4 million in 1979 to 36.8 million in 1986. Although population growth accounts for part of the increase, CRS found that this factor accounted for less than 30 percent of the growth between 1979 and 1986. This growth in the number of uninsured can also be attributed, CRS maintains, to

- increases in the percentage of the nonaged population in the work force;
- increases in employment in service industries, where insurance coverage has been limited;
- decreases in the percentage of the population under the age of 18 who traditionally would have been covered under their parents' health insurance;
- increases in the number of nonaged living outside of traditional family arrangements;
- employees' interest in cash rather than noncash compensation because of decreased inflation and changes in the tax structure; and

- decreased coverage for dependents caused by increases in the cost of this coverage, which must be paid by the insured.[1]

GAO's analysis of the CPS data showed that although the number of uninsured Americans under the age of 65 increased 13 percent from 1982 to 1985, the number of working uninsured grew 22 percent during the same period. Reduced access to health insurance through employment appears to be a major factor in the growth of the uninsured.

Lack of Insurance Affects the Uninsured and Society

Lack of insurance affects the uninsured and society at large in several ways. The 1986 National Access Survey reported that the uninsured are less likely to use health care services and are more likely to be in poor health than the insured.[2] When the uninsured do receive health services, they do not always receive free or charity care; many uninsured pay for all or some of their medical care. When they do pay, the uninsured tend to pay more out-of-pocket expenses than the insured.[3] Because the uninsured also tend to have low incomes, they may not be able to pay for all of their health care. The amount of uncompensated care (care provided to a patient that the hospital is not reimbursed for) more than doubled

[1]CRS, Health Insurance and the Uninsured: Background Data and Analysis (June 9, 1988).

[2]The National Access Survey, conducted by the Robert Wood Johnson Foundation, is one of the few studies that attempts to document access barriers to the health system. The nationwide household telephone survey of 10,130 randomly selected persons was conducted between the spring and fall months in both 1982 and 1986, with a completed response rate for the 1986 survey of 76 percent. The results of the 1986 survey (the seventh in a series of national household surveys on access to health care) provide information on the changes in the frequency of physician, emergency room, and hospital visits; regular sources of care; satisfaction with treatment; health status; access to care and reasons for being denied treatment; health insurance status; and demographic data. To determine if patterns of health care use and expenditures were different for those without telephones than for those with telephones, face-to-face interviews were done with 300 persons without telephones in three geographically dispersed and culturally diverse locations. The results indicate that twice as many persons without telephones are uninsured (18 percent) compared with those with telephones (9 percent).

[3]The term "out-of-pocket expenses" is defined by the Health Insurance Association of America as "those medical expenses which an insured is required to pay because they are not covered under the group contract."

between 1980 and 1984.[5] It is likely that most uncompensated care costs are generated by uninsured patients.[6]

By billing private insurers at rates exceeding costs (commonly referred to as cost-shifting), hospitals frequently attempt to shift some of the costs of uninsured patients to insured patients. As hospital cost-shifting has been constrained in recent years by various health cost-containment measures, hospitals increasingly want to treat only insured patients and attempt to transfer uninsured patients for economic rather than medical reasons (referred to as patient-dumping).[7] Evidence suggests an increase in the number of these patient transfers.

Objectives, Scope, and Methodology

At the request of the Chairman of the Senate Finance Committee, we gathered data on the working uninsured and, where appropriate, identified gaps and limitations in the available data. Specifically, to respond to the Chairman's request, we addressed the following questions:

- What are the distinguishing characteristics of the uninsured?
- Do the working uninsured lose more time from work than the working insured?
- What kinds of employers do not provide health insurance, and where are they located?
- What reasons do employers give for not offering health insurance to their workers?
- Do workers without employer-sponsored health insurance have alternative coverage?
- Where do the working uninsured obtain care?
- What types of medical bills do the uninsured incur?

[5] American Hospital Association (AHA), Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, A Report of the Special Committee on Care for the Indigent (1986), p. 11.

[6] Using three national data bases—the AHA Annual Survey of Hospitals, the Survey of Medical Care for the Poor and Hospitals' Financial Status, 1983 (jointly conducted by AHA and the Urban Institute), and the 1981 Hospital Discharge Survey—the authors determined that "... there is a significant relationship between the percentage of total hospital charges to 'self-pay' patients and the amount of uncompensated care the hospital provides." Although we cannot definitively claim that self-paying patients are uninsured, and this is a major gap in the available data on the uninsured, it is a logical assumption. If such patients were insured, on discharge, they would probably claim their insurance company as the primary or secondary payer source.

[7] Health Care: Patient Transfers From Emergency Rooms to D.C. General Hospital (GAO/HRD-87-31, Apr. 30, 1987); David Himmelstein and others, "Patient Transfers: Medical Practice as Social Triage," American Journal of Public Health, Vol. 74, No. 5 (1984); and Robert Schiff and others, "Transfers to a Public Hospital: A Prospective Study of 467 Patients," The New England Journal of Medicine, Vol. 314, No. 9 (Feb. 27, 1986).

- Who pays the medical bills of the uninsured?
- What policy options exist for sponsoring health insurance for the uninsured?
- What changes in insurance have occurred as a result of recent legislation affecting terminated workers?

Because a substantial number of studies have addressed the uninsured, we agreed to answer these questions, to the extent possible, using existing data. Although a wealth of descriptive data is available on the uninsured, gaps in information critical to policymakers still exist; in part, this is because of methodological limitations in some of the current research. The most critical gap we encountered in preparing this report has been the scarcity of specific data on the working uninsured, particularly their sources of health care, the types of medical bills they incur, and the sources of payment for those bills. We have, therefore, used data on the uninsured population as a whole to answer several of the questions posed; however, we have cited data on the working uninsured when available.

To provide information on the characteristics of the uninsured population as a whole, we used a GAO analysis of March 1986 CPS data, discussed in a report to Senator Howard Metzenbaum.[1] More information and a detailed description of our methodology for this analysis appears in that report. We also identified 12 national databases on the uninsured and reviewed the methodologies; we noted the limitations (for example, low response rates for surveys and noncomparable populations). In addition, we reviewed the content and results of over 200 research studies and discussed these studies with experts in the health policy area. Finally, we present information on the research and opinions in the literature we reviewed. We also present our own opinions on where additional research may be needed. We did not verify the cost estimates for the various options proposed by researchers to reduce the number of uninsured.

Copies of the draft report were made available to the National Federation of Independent Business, the ERISA (Employee Retirement Income Security Act) Industry Committee, and Lewin and Associates, Inc. Their comments were included as appropriate.

Our work was done between July 1987 and February 1988.

[1] Health Insurance: A Profile of the Uninsured in Ohio and the Nation.

Chapter 2

Characteristics of the Uninsured

Several recent analyses of working-age (18 to 64 years of age) people (including those by GAO, the Employee Benefit Research Institute [EBRI],[1] and the Urban Institute[2]) show that the uninsured are most likely to be young (19 to 24 years of age), nonwhite, single, poorly educated, and employed in low-income jobs, frequently on a part-time or part-year basis.

Demographic Characteristics of the Uninsured

Age

During 1985, almost 30 percent of those 19 to 24 years of age had no health insurance compared with 12 to 16 percent among other groups between the ages of 25 and 64, according to GAO's analysis. An Urban Institute analysis of March 1984 CPS data reported similar findings: 29 percent of those 18 to 24 years of age were uninsured.

Several explanations have been suggested for the disproportionately high percentage of uninsured among this age group:

- This group is just entering the job market and may (1) not have worked long enough to be eligible for health insurance sponsored by employers or (2) be working in industries that do not offer insurance. About 53 percent of workers in this age group were in the six industries most likely not to offer health insurance, CPS data show.
- As income levels for this age group are generally below those for older workers, this group may be unable to purchase insurance. In fact, 81 percent of the uninsured in the group aged 19 to 24 earned less than $10,000 in 1985, according to Census data.
- Health coverage, which may have been available through a parent's plan, may no longer be available since insurers frequently drop coverage for dependents at the age of 19 (or 22, if the dependent is a student). Of those aged 18 to 20 with employer-sponsored private health insurance, over two-thirds obtained that insurance as dependents. In the aged 21 to

[1]EBRI, A Profile of the Nonelderly Population Without Health Insurance (May 1987).

[2]Margaret Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care: A Chartbook, Urban Institute (June 1986).

24 group, however, only about 18 percent of those with employer-sponsored private insurance obtained that insurance as dependents.

- The younger group, generally in better health than older groups, may not believe they need health insurance or may believe that they would be subsidizing the insurance costs for older age groups.
- Limited assets and fewer family responsibilities may contribute to this group's accepting more risk than older groups.
- This group may be more likely to be employed part-time and therefore ineligible for health insurance under the employer's plan.

According to EBRI, 20 percent of the uninsured children live with a parent who has employer-sponsored insurance. Available data, however, do not indicate whether (1) the insured worker's plan did not offer dependent coverage or (2) dependent coverage was available but the worker did not elect to take it. According to the National Federation of Independent Business (NFIB), small employer plans offer more dependent coverage options than larger employers.

Race and Ethnicity

Race and ethnicity also influence the probability of being uninsured in the United States. The percentage of Hispanics and blacks who are uninsured is much higher than the percentage of whites, even though 64 percent of all uninsured are white. GAO and Urban Institute analyses both report 15 percent of whites are uninsured, but at least 24 percent of blacks and 32 percent of Hispanics are uninsured. These figures are not surprising because blacks and Hispanics are also more likely to be unemployed or employed in low-wage jobs, two other predictors of whether or not they have insurance coverage.

Marital Status

The likelihood of being uninsured is greater among the unmarried than the married. Nationwide, married people made up 63 percent of the population aged 19 to 65 in 1985; however, only 11 percent were uninsured. Never-married people in this age range made up 23 percent of the U.S. population; 28 percent of these people were uninsured.

Education

The likelihood of being uninsured decreases as a person's education increases. For example, of those whose education ended with grade school, about 31 percent were uninsured in 1985 compared with 12 percent of those completing 1 or more years of college.

Although few studies have examined how education relates to insurance, a positive correlation between education and income exists (that is, as education increases, so does income), which may partially account for the relationship. Income, as discussed later in the chapter, is a predictor of health insurance. Thus, education's correlation with income may explain its correlation with health insurance.

Most Uninsured Linked to the Work Force

Our analysis of the March 1986 Census CPS data indicates that in 1985, about 72 percent of the uninsured between the ages of 19 and 65 were employed at some time during the year, with 28 percent being employed full-time (35 or more hours per week) for at least 50 weeks during the year. Another 44 percent were either employed part-time (less than 35 hours per week) or less than 50 weeks during the year or both. The other 28 percent of the uninsured between the ages of 19 and 65 were either unemployed or not in the work force during 1985 (see table 2.1).

From 1982 through 1985, the percentage of the uninsured who were employed full-time for a full year increased 24 percent; the percentage who were unemployed or not in the work force declined about 16 percent. These changes reflect the expansion of the work force in areas with traditionally low insurance coverage rather than (1) a decline in existing employer-provided health insurance or (2) an increase in Medicaid or other public insurance programs.

[1]Conducted annually by the Bureau of the Census, CPS collects data on individuals, families, and households for the civilian, noninstitutionalized population in the United States. It provides monthly data on labor force activities—including data on employment status, occupation, industry, weeks and hours worked, reasons for not working full-time, total income, and demographic characteristics. The health insurance data are found in the March supplements, entitled "Characteristics of Households and Persons Receiving Selected Noncash Benefits." Through interviews with some 58,000 households with 122,000 individuals over 14 years of age, these supplements provide data on work experience, income, noncash benefits, and migration. Also included are 34,000 children within these households. The monthly response rate is estimated at approximately 82 percent. (This percentage was obtained by dividing the number of interviewed households, 58,000, by the number of assigned households, 71,000; the percentage represents the response rate that is due to attrition, resulting from interviewers' inability to locate respondents). The multistage, stratified random sampling procedure is designed to provide national estimates. The sampling frame is adjusted after each decennial census to correct for demographic changes in the population; these adjustments are phased in over time and take over a year to be completed. Because the sample is chosen to be nationally representative, the regional, state, and local data produced during the changeover period (for example, during 1985-86) may not be reliable.

Table 2.1: Employment Status of the Uninsured Aged 19 to 65 (1982 and 1985)

In percent

	Distribution	
Employment status	**1982**	**1985**
Full-year, full-time[a]	22.7	28.2
Part-year, part-time[b]	44.5	44.1
Nonworker[c]	32.8	27.7

[a]Those employed at least 35 hours per week, 50 weeks per year.

[b]Those employed less than 35 hours per week or less than 50 weeks per year or both; those who worked full-time for part of the year are also categorized as part-time employees.

[c]Those who were either unemployed the entire year or were not in the work force.

Source: GAO analysis of March 1986 CPS data.

Although we focused our analysis on the employment status of uninsured working-age people, EBRI (also using the March 1986 CPS data) analyzed the employment status of the heads of households for families with uninsured members of any age.

EBRI found that more than three-fourths (77.5 percent) of the uninsured population lived in families in which the family head worked or sought work for the full year (35 weeks or more).[1] Of those family heads, 52 percent worked full-time (35 or more hours per week); another 8 percent were steadily employed on a part-time basis for 35 or more weeks. Another 17 percent worked full-time for 35 or more weeks but were unemployed some of the time. Only 9 percent of the uninsured lived in families in which the family head worked or sought work less than 35 weeks per year; 14 percent lived in families in which the head of the family neither worked nor sought work at any time during the year. This distribution of the uninsured by the work status of the family head is presented in table 2.2.

[1]"Family head" is defined as the family member with the greatest earnings.

Table 2.2: Analysis of the Uninsured by the Employment Status of Family Heads(1985)

In percent

Employment status of family head	Uninsured
Full-year, full-time[1]	52.3
Full-year, part-time[2]	8.0
Sometimes unemployed[3]	17.2
Part-year	9.2
Nonworker[4]	13.5

[1]Includes only steadily employed, full-year workers.

[2]Includes only workers that worked or sought work 35 weeks or more during the year.

[3]Includes both steadily employed and sometimes unemployed workers that worked or sought work fewer than 35 weeks.

[4]Includes only those individuals who neither worked nor sought work at any time during the year.

Source: EBRI analysis of March 1986 CPS data.

Importance of Income to Insurance Availability

As income increases, so does the percentage of people with health insurance. As shown in table 2.3, about 38 percent of the population in the United States living in families with income below the federal poverty level were uninsured.[5] This compares with less than 10 percent of those in families with income of at least twice the poverty level. Although those with low income are more likely to be without health insurance, over one-third of all uninsured are in families with income at least twice the poverty level.

Table 2.3: Relationship of Family Income to Health Insurance for Individuals Under the Age of 65 (1985)

In percent

Ratio of family income to poverty	Population	Uninsured (in each group)
Under 1.0	15.1	38.5
1.0-1.99	18.5	28.3
2.0 and over	66.3	9.9
Total	**99.9**	[a]

[a]Not applicable.

Source: GAO analysis of CPS data, March 1986.

Researchers agree that in 1985, the total money earnings for most of the working uninsured was less than $10,000 a year and for nearly all, less

[5]In 1985, the federal poverty level was $10,989 for a family of four.

than $20,000.[1] As illustrated in table 2.4, EBRI's analysis indicates that three-fourths of the working uninsured earned less than $10,000; only 7 percent earned $20,000 or more per year.

Table 2.4: Total Money Earnings of Uninsured Workers Aged 18 to 64

	Uninsured workers	
Total money earnings	**In millions**	**In percent**
Less than $10,000	12.3	74.5
$10,000-19,999	3.1	18.8
$20,000 or more	1.1	6.7
Total	**16.5**	**100.0**

Source: EBRI, "A Profile of the Nonelderly Population Without Health Insurance" (May 1987), p. 16

The relatively low earnings reported by uninsured workers, EBRI maintains, were not necessarily related to part-time or part-year work. Among full-year workers without health insurance, 69 percent earned less than $10,000 in 1985. About one-third of all full-year workers earning less than $10,000 were uninsured.

Even when income from nonwage sources (such as interest, dividends, and pension benefits) is included in the calculation of an individual's annual income, 65 percent of the working uninsured had income below $10,000; 11 percent had income greater than $20,000 per year, as shown in table 2.5.

Table 2.5: Income Levels of Uninsured Workers Aged 19 to 65 (1985)

In percent

	Uninsured workers		
Income	**Full-year and full-time[a]**	**Part-year or part-time[b]**	**Total**
$1-9,999	15.4	49.1	64.5
10,000-19,999	15.4	9.0	24.4
20,000 and over	8.3	2.8	11.1
Total	**39.1**	**60.9**	**100.0**

[a]For 50 or more weeks, 35 or more hours per week

[b]Less than 35 hours per week or less than 50 weeks or both

Source: GAO analysis of March 1986 CPS

[1]"Total money earnings" is defined by the Bureau of the Census as the sum of the amounts of (1) wages or salaries received by employees for pay; (2) net nonfarm self-employment income received by people operating their own nonfarm business, partnership, or professional practice; and (3) net farm self-employment income received by people operating farms.

Relationship of Time Lost From Work to Insurance Availability

A report based on the 1977 National Medical Care Expenditures Survey (NMCES) data, using disability days as a measure of time lost from work,[7] indicates no substantial difference between the working insured and uninsured. Because other factors may be involved in an employee's decision to take time off from work, we cannot, however, draw conclusions about the effect of insurance status on the number of disability days. Of the working uninsured, 11 percent had 8 or more disability days compared with 12 percent of the working insured.

[7]NMCES was conducted between 1977 and 1979 by the National Center for Health Services Research (NCHSR). The goal of the survey was to inform national health policy decisionmakers by documenting the patterns of health expenditures and health insurance of the U.S. civilian noninstitutionalized population. Data were obtained from three sources—individuals, health care providers, and employers and insurance companies. The study consisted of 14,000 randomly selected households, interviewed six times over an 18-month period during 1977 and 1978. The survey began with a 91 percent response rate in the first round of interviews, dropping to 82 percent by the fifth round. Physicians and representatives of health care facilities providing care to household members during 1977 were interviewed. Approximately 16,000 employers and insurance companies (covering the 85 percent of the respondents who signed consent forms) were also interviewed. NCHSR has published a number of analytical reports based on this study; despite the age of the survey, NMCES continues to be one of the most widely used data sources for health policy research. The 1977 NMCES is currently being updated by the National Medical Expenditure Survey (NMES).

Further Analysis Needed to Determine Why Some Businesses Do Not Offer Health Insurance

Generally, the businesses least likely to offer health insurance are those that provide low-wage or low-skill employment opportunities; businesses with fewer than 100 employees; new businesses; and businesses in the southern and western regions of the United States. Recent studies by the Small Business Administration (SBA) and NFIB found that businesses most frequently cite insufficient profits and high insurance costs as reasons for not offering health insurance to their employees.

Although research on employer-sponsored insurance is extensive, there are gaps in the information and methodological limitations in some studies. For example, the studies (1) are generally descriptive rather than explanatory, (2) use databases that are not comparable or that exclude certain sectors, or (3) are based on surveys with low response rates. Further research is needed on the reasons why businesses do not offer health insurance.

Characteristics of Businesses That Do Not Offer Health Insurance

Industry

The availability of health insurance appears to be related to the type of industry the business is part of. As shown in table 3.1, construction, retail trade, and service industries (such as business and repair,[1] entertainment and recreation, and personal services) are least likely to offer health insurance. As also shown in table 3.1, retail trade and service industries (particularly business and repair services) have been among the fastest growing in recent years. The Bureau of Labor Statistics (BLS) projects that the service industry will account for a total net increase of 11.3 million jobs in 1984-95: retail trade will gain 2.9 million jobs, but the goods-producing industry will increase by only 1.8 million jobs.[2] If the rates of health coverage remain the same and the BLS projections of job growth are realized, the problem of access to employer-sponsored health insurance could be exacerbated.

[1]For example, advertising, credit reporting, and claims collection are considered business services. Repair services include automotive repair services and parking or miscellaneous services.

[2]Janet L. Norwood, "The Labor Force of the Future," Business Economics, Vol. 22, No. 3 (July 1987), p. 10. Data cited in the article are from the Bureau of Labor Statistics, March 1986.

Table 3.1: Employer-Offered Health Insurance by Industry Type (1985)

Industry	Employees, 1985[a] (thousands)	Employment growth, 1982-85 (percent)	Working uninsured, 1985[b] (percent)
Low level of uninsured workers			
Finance, insurance, and real estate	7,170	14	8.3
Manufacturing:			
Durable	13,320	0	6.9
Nondurable	8,980	−1	11.0
Mining	1,110	−10	8.4
Professional and related services	23,020	5	9.9
Public administration	5,390	10	4.9
Transportation, communication, and public utilities	7,970	9	9.8
Wholesale trade	4,530	1	10.9
Subtotal	**71,490**		
High level of uninsured workers			
Business and repair services	6,570	26	23.4
Construction	7,820	13	26.8
Entertainment and recreation	1,360	8	25.6
Personal services	4,400	12	29.6
Retail trade	18,320	8	23.4
Subtotal	**38,470**		
Total	**109,960**		

[a]Excludes agriculture, forestry, fisheries, and miscellaneous services.

[b]Includes wage and salary workers, but excludes the self-employed. According to EBRI, which also uses CPS to estimate the uninsured, about 24 percent of the self-employed, accounting for 9.7 million workers in 1985, had no health coverage.

Source: CPS, Bureau of the Census, March 1986.

Size

The availability of health insurance and business size appear to be directly related. Data from the Survey of Income and Program Participation (SIPP) indicate that the largest number and percentage of working uninsured work for businesses with fewer than 25 employees,[c] as shown in table 3.2.

[c]SIPP is a national survey initiated in 1983 by the Bureau of the Census. Designed to provide comprehensive information on the economic situation of households and individuals in the United States, it is a longitudinal study consisting of a series of overlapping panels (each panel is interviewed every 4 months for 2-1/2 years). SIPP is the first survey to collect information on cash and noncash income, eligibility and participation in various government transfer programs, labor force status, and assets and liabilities. For the survey, 15,600 households were interviewed in the 1984 panel, with a 75 percent response rate, and 13,300 households in the 1985 panel, with an 80 percent response rate. Data on the 1984 panel are currently available for public use. The 1985 data are forthcoming.

Table 3.2: Uninsured Private Wage-and-Salary Workers by Business Size (1984)

Business (employee number)	Uninsured (millions)	Uninsured (percent)
1-24	3.9	48
25-99	1.2	15
100-499	1.0	12
500 or more	2.1	26
Total	**8.2**[a]	[b]

[a]This includes only private wage-and-salary workers. The remainder of the 32 million uninsured (as estimated in 1984 by the Bureau of the Census) are business owners (1.6 million), government, farm, or household workers (1.6 million), those looking for work or on layoff (3.7 million), or those outside of the work force, including children, the unemployed, and students (16.7 million).

[b]Does not add up to 100 percent because of rounding.

Source: Report of the President, 1987, SBA, p. 140.

The Employee Benefits in Medium and Large Firms survey, conducted annually by BLS,[1] reported that in 1985, 95 percent of full-time, permanent employees of businesses with 100 or more employees have employer-sponsored health insurance. Similarly, a study conducted by ICF, Inc., for SBA found that 97 percent of employees in businesses with 100 or more employees worked for businesses that offered health insurance.[2] These statistics, however, can be misleading because not all workers may be eligible for the insurance. This is particularly true for part-time or temporary employees.

Age

The age of a business may be a factor in whether an employer offers health insurance. Of businesses in existence over 10 years, 63 percent

[1]The BLS annual survey, Employee Benefits in Medium and Large Firms, reports data on benefits provided by (1) businesses in the private sector with 100 or more employees and (2) some selected service industry businesses with 50 or more employees. The survey covers 14 types of employer-provided benefits, but excludes part-time, temporary, and seasonal workers; traveling and operating personnel; and executives who are policy-makers. If benefit plans require an employee to pay part of the cost, employees are counted only if they are employed full-time, elect to receive the employer's benefit package, and have paid their share of the cost. The survey does not indicate the number of employees who either have no access to employer-sponsored health insurance or choose not to participate. In the 1986 survey, 1,503 firms were selected by a weighted, stratified random sampling procedure; the survey has a response rate of approximately 91 percent (the rate for the health insurance part is lower, about 80 percent, because of missing information).

[2]SBA conducted a survey of businesses in 1986 using the Dun and Bradstreet U.S. Enterprise and Establishment Microdata File, which contains a listing of approximately 3.7 million businesses. The probability sample, stratified by five size categories and seven industry categories, generated a list of 4,375 businesses or 125 businesses per cell. The response rate for usable surveys was only 20 percent, but SBA reports that the nonresponse bias test was negative. The survey provides a profile of the selected businesses, including data on age (as of 1985), revenues, payroll, fringe benefits, eligibility criteria for participation in benefit plans, types of plans offered, employee contributions, cost-containment measures used, and demographic characteristics of employees. The information is published in Health Care Coverage and Costs in Small and Large Businesses: Final Report, SBA (Apr. 15, 1987).

offered insurance as compared with 44 percent in existence 10 years or less.[1] One explanation could be that many new businesses may not be willing to incur the cost to offer health insurance until the profitability of the business is well established.

Location

Data from the March 1986 CPS show that the businesses least likely to offer employees health insurance are located more in the southern (South Atlantic, East South Central, and West South Central) and western regions (Mountain and Pacific) than in the rest of the United States, as shown in table 3.3.

Table 3.3: Health Insurance Sources of Population Under 65 Years of Age by Region (1985)

		Sources		
Region	**Total[a] (thousands)**	**Total private insured (percent)**	**Total public insured[b] (percent)**	**No insurance (percent)**
East				
New England	10,733	80.9	9.9	12.1
Middle Atlantic	31,412	75.2	13.0	14.4
North				
East North Central	35,678	76.2	13.3	13.7
West North Central	13,928	78.4	10.6	14.1
South				
South Atlantic	32,627	73.1	12.0	18.8
East South Central	12,511	70.4	11.8	21.1
West South Central	22,487	69.9	9.8	23.4
West				
Mountain	10,889	74.7	9.6	19.4
Pacific	29,499	70.3	13.3	20.2
Average		73.9	12.0	17.4
Total	**199,764**			

[a]Numbers do not include individuals in military or agricultural sectors

[b]Medicaid recipients

Source: EBRI, "A Profile of Nonelderly Population Without Health Insurance" (May 1987), pp. 14-15

Regional differences in health insurance coverage among the employed may reflect the greater degree of industrialization and unionization in regions with higher numbers of working insured. For example, in 1984,

[1]Health Care Coverage and Costs in Small and Large Businesses, table III-8

69 percent of production workers in the Midwest were covered by collective-bargaining agreements (which often include health insurance), compared with 32 percent in the South. On the other hand, regions with higher numbers of uninsured may reflect the greater incidence of small and service-sector businesses. These businesses tend to hire nonunion workers more than businesses in the manufacturing industry. It is, therefore, not clear what factors are most critical in explaining these regional differences.

Reasons Employers Give for Not Offering Health Insurance

In two recent studies by SBA and NFIB,[7] employers most frequently cited either insufficient profits or high insurance costs as reasons for not offering health insurance. Although both surveys have methodological limitations and low employer response rates, the results were generally consistent and provide some indication of employer thinking (see table 3.4).

Table 3.4: Reasons for Not Offering Health Insurance Reported by Small Businesses

In percent

Reason	SBA[a]	NFIB[a]
Business insufficiently profitable	67	20
Insurance costs too high	62	33
Employee covered under spouse's or parent's policy	•	26
Employee turnover too great	19	15
Group coverage not available	16	19
Employee not interested	13	•
Employees prefer wage compensation	•	8
Administrative costs too high	9	8
State-mandated benefits	1	•
Other	9	4

[a]Responses add up to more than 100 percent because of multiple answers

Sources: SBA, Office of Advocacy, "Health Care Coverage and Costs in Small and Large Businesses" (Apr. 1987), p. III-15, and NFIB, "Small Business Employee Benefits" (Dec. 1985), p. 26

[7]Two surveys were conducted by NFIB, one in 1978 and one in 1985. Both surveys sent mail questionnaires with a 2-week follow-up to a randomly selected sample of small businesses. All regular members were eligible except for those businesses with no full-time employees. The 1978 survey, conducted from mid-May to mid-June, of 6,492 NFIB members, resulted in a total of 1,608 usable surveys, giving a response rate of 25 percent. For the 1985 survey of 7,750 businesses, 1,439 usable surveys were returned, giving a response rate of 19 percent. Although at least one expert considers both response rates unacceptable for purposes of generalization, NFIB claimed that the 1985 usable responses did not significantly differ from either the survey sample or the estimated universe of small businesses. The results of the survey are available from NFIB.

Profits and Costs Interrelated

Insufficient profits and high insurance costs are two frequently cited and interrelated reasons businesses give for not offering health insurance. In both the SBA and NFIB studies, businesses reported that health insurance is increasingly too expensive relative to their financial position. EBRI found that businesses' health care costs rose nearly 280 percent between 1974 and 1984; the Health Insurance Association of America found that insurance premiums rose about 45 percent between 1980 and 1983. For comparison, prices in general rose almost 100 percent between 1974 and 1984 and 22 percent from 1980 to 1983.[9]

Insurance costs are generally higher for small businesses. A 1987 SBA report,[10] in comparing small businesses with larger ones, found that small businesses pay 10 to 40 percent higher premiums for comparable plans and benefits. This is so for a number of reasons. First, the estimated cost to a business of sponsoring health insurance is approximately 25 percent of the minimum wage ($3.35 an hour) per employee,[10] about $0.84 per hour per employee. Because small businesses tend to have more low-wage employees, health insurance costs represent a greater percentage of total compensation (wages plus benefits) for these businesses as compared with larger businesses. Particularly affected, according to NFIB, are labor-intensive businesses (such as maid services and painting contractors). NFIB maintains that if premiums were lower, greater coverage would be provided. Also increasing the cost of insurance are state mandated-benefits laws. Such mandates, the ERISA (Employed Retirement Income Security Act) Industry Committee claims,[11] increase costs and inhibit the ability of businesses to provide employees with basic and economical benefits packages.

In addition, small businesses are more likely to be sole proprietorships or self-employed. Generally, under the Internal Revenue Code (section 162(a)), employer contributions to employee health plans are fully deductible. However, under the Tax Reform Act of 1986 (P.L. 99-514), a self-employed person may deduct only 25 percent of his or her health insurance costs. Furthermore, small businesses are frequently offered standard plans and may not be able to negotiate lower levels of benefits, higher deductibles, or higher copayments (or all three) to achieve cost

[9]As measured by the implicit price deflator for the gross national product.

[10]The State of Small Business, SBA, p. 167.

[10]Beth Fuchs, "Access to Health Insurance," CRS Seminar (Jan. 14, 1988), p. 2.

[11]The committee is a trade association of large corporate pension and welfare benefit plans.

savings. Too, small businesses are more likely to change insurance carriers, and there are costs associated with these changes. Finally, certain costs associated with providing health insurance are fixed, such as sales, eligibility determination and verification, and collection. Large businesses have more workers over which to spread these fixed costs.

Alternative Coverage and Worker Turnover Also Cited

In the NFIB study, over 25 percent of small businesses stated they do not offer insurance because their workers are already covered by spouses' or parents' insurance; this is especially true, businesses say, of part-time, temporary, and seasonal workers. Data supporting this claim of alternative coverage, however, are limited. Data are based on the total population not on the employed (see table 1.1); therefore, they do not show whether a worker who does not have employer-sponsored health insurance has another source of insurance (for example, Medicare) or is uninsured. The 36.9 million uninsured (shown in table 1.1) is an estimate of the number of those who have no health insurance, not an estimate of the number of working people without health insurance.

Another reason why some businesses do not offer health insurance, cited by 15 to 19 percent of businesses in both the SBA and NFIB studies, was because these businesses had a high turnover rate for workers. In the studies, 8 to 13 percent of businesses reported they did not sponsor health insurance because workers were not interested or would rather have higher wages than paid health insurance. For example, young workers, in particular, were believed to prefer higher wages to health insurance because they are usually healthy and do not feel they need insurance.

Group Coverage Not Available

Another frequently cited reason small businesses give for not offering health insurance is the unavailability of group coverage. This problem exists, according to NFIB, when businesses are too new to qualify for coverage or are in an industry for which many insurance companies do not offer coverage.

NFIB said that small businesses tend to operate in distinct and specialized niches and that insurance companies do not offer coverage to businesses in certain industries. This, NFIB notes, leaves the small business owner out in the marketplace with no information and with limited resources to find an insurance carrier that does write insurance for a specific industry. According to NFIB, the information gap is significant for both

finding coverage and controlling costs or increasing benefit levels of plans already in existence.

In a separate report, being prepared at the request of the Chairman, Senate Committee on Labor and Human Resources, we will be providing further information about restrictions on the availability of health insurance coverage to small businesses.

Analysis of Research Limitations

Although the research on employer-sponsored health insurance is extensive, there are gaps in the available information and limitations on its usefulness, for example:

- Much of the existing research describes the characteristics of the working uninsured, but does not explain why they are uninsured. Without knowing the underlying reasons why workers do not have health insurance, it is more difficult to decide which policy option will most effectively reduce the number of uninsured.
- Analyses of the same data can give different results about the characteristics of the working uninsured because of the different ways in which terms such as "part-time" are defined. Policymakers need to be aware of such definitional problems in designing and evaluating policy options.
- The usefulness of some studies is limited because (1) data were not collected on certain segments of the population or (2) survey response rates were low. These limitations raise questions about whether the data accurately and completely portray the characteristics of the uninsured.

Descriptive Studies

Most studies of the uninsured are descriptive rather than explanatory. They provide information on the characteristics of the working uninsured, but they do not address the question of why they are uninsured. Furthermore, the links between the various factors that affect a worker's insurance status have not been fully explored. For example, the literature consistently indicates that workers in small, new, and service-sector businesses are least likely to have employer-sponsored health insurance. These business characteristics are related to each other—many new businesses are small and many service-sector businesses are both new and small. It has not, however, been determined which factor or set of factors explains the decline in employer-sponsored insurance.

Comparability of Databases

One limitation of existing research relates to the comparability of databases. Variations in the way data are collected affect analysts' ability to compare different study results. For example, the BLS annual survey separates businesses on the basis of the number of workers in order to indicate the size of the business. These groupings are businesses with 50; 100; 250; 500; 1,000; and so on, up to 10,000 workers. EBRI, however, determines business size by 25, 100, 500, and 1,000 workers. Because of these differences, the studies may be describing different groups of workers when analyzing the rates of employer-sponsored health insurance by business size.

A related issue is that various estimates of the working uninsured may not include the same groups of people. For example, some studies estimate the lack of insurance only among people between the ages of 18 and 64; some include all people under the age of 65, and others use the entire national population.

Exclusion of Certain Sectors From Databases

Several sectors of the population either have not been included in the databases we reviewed or may need to be examined more closely. These sectors include (1) agricultural and service industries, (2) part-time and temporary workers, and (3) people who are not eligible for health benefits through work even though they may work for businesses that offer health insurance to other workers. This is important because many businesses are counted as providing health insurance to their work force regardless of how many of their workers are not eligible for benefits; data collected on these businesses may not accurately portray the number and types of businesses that provide health insurance.

The agricultural sector is frequently excluded from studies of the uninsured. An EBRI official noted that the characteristics of this group—including high mobility, heterogeneity, and a large number of undocumented workers—make it difficult to gather dependable data. The working uninsured in the service sector have not been closely examined. Although this sector continues to be the fastest growing one in the labor market, this sector is not homogeneous because it includes both high-paying and low-wage jobs. For example, almost half of all jobs created in 1986 were professional or managerial, with above-average pay across all industries. This may help to explain the data indicating that some small businesses do sponsor insurance. Links have not yet been established between the increasing number of small businesses, the growth and diversity of the service sector, and a business's decision not to sponsor insurance for its workers. More research is needed in this area.

Finally, many databases exclude workers who are not eligible for employer-sponsored insurance. Two notable examples of this type of exclusion are found in a 1980 national survey of employer-sponsored health insurance for both large and small businesses.[12] Although the response rate in the 1980 survey was high and the sample was representative, the study did not cover employees with no access to health benefits through employment. The BLS annual survey excludes part-time, temporary, and seasonal employees, who are among the groups least likely to have employer-sponsored health insurance. Although these employees have traditionally been considered members of the secondary (marginal) work force (that is, second-income earners rather than primary-income earners for the family), they have recently become a major part of the work force. As a result of these employees' exclusion from the BLS survey, little information is available about the characteristics or size of the secondary work force. In addition, our review of the literature did not identify any study that examined variations in employers' eligibility requirements for their sponsored insurance.

Low Response Rates for Surveys

We identified only two survey that have attempted to document why certain employers do not sponsor health insurance. The SBA survey had a 20 percent response rate. If the employers that responded have different characteristics from those that did not, the low response rate is a potentially serious problem. According to SBA, there was no difference between respondents and nonrespondents. It is possible that new businesses with fewer than 10 employees or from 10 to 19 employees were, however, disproportionately represented in the nonresponse group. This could be because these businesses traditionally have higher failing rates in the first year of business than businesses with 20 or more workers. The 1985 NFIB response rate of 19 percent has the same potentially serious problem. Furthermore, the survey sample was drawn from members of NFIB. Since its members may be better established, this sample could understate the problems small businesses have in providing insurance.

[12]The Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79, study was sponsored by the Department of Labor under contract to the Battelle Human Affairs Research Center. The study sought to (1) develop profiles of plans and plan sponsors; (2) determine eligibility rules and their relationship to contribution rates, administrative and funding arrangements, and other benefits; (3) examine changes in the types and scope of benefits offered to employees; and (4) examine the impact of ERISA on plan operations and administration. Battelle, using a stratified random sampling technique, drew two samples because of the availability of employer lists: one sample for small employers (less than 100 employees) and one sample for medium-to-large employers (100 or more employees). From December 1978 to February 1979, data were collected by telephone interviews and by soliciting written descriptions of employers' plans. Battelle obtained 1,273 completed usable interviews for large employers, resulting in a 77 percent response rate, and 1,170 for small employers, resulting in an 81 percent response rate.

For example, the unavailability of insurance coverage for new businesses could be understated as a problem for small businesses because most NFIB members have been in business long enough that such restrictions no longer apply.

Health Care for the Uninsured

Questions that need to be considered in developing solutions to the problem of how to provide health care to the uninsured include (1) where the uninsured obtain health care, (2) what types of bills they incur, and (3) who pays those bills. The research available to answer these questions comes in a variety of forms—national data (such as the NMCES, SIPP, and CPS data), case studies at state and local levels, surveys directed at certain target groups or issues (such as the Robert Wood Johnson Foundation National Access Survey), and studies that use indirect or proxy measures (such as studies of uncompensated care[1]). Each type of research has certain limitations. For example, studies frequently use old data, exclude certain types of data, use proxy measures to determine the cost and delivery of services to the uninsured, or are not based on comparable target groups or data.

Despite these limitations, in combination, the studies provide a fairly coherent, although incomplete, picture of health services provided to the uninsured. Briefly, the uninsured are most likely to obtain health care services at public and teaching hospitals in metropolitan areas. Most of the medical bills incurred by the uninsured are for maternity cases and accidents. Health care services provided to the uninsured are paid for directly—by the uninsured themselves out of pocket and by public funds and philanthropy—and indirectly—through cost-shifting to those that have the ability to pay.

[1]"Uncompensated care" is defined as unreimbursed services and consists of two parts—bad debts and charity care. Bad debts refer to services that are billed to—but not collected from—patients, including debts of insured patients who do not pay their copayments or deductibles or both and debts of the nonpoor uninsured. Charity care refers to services for which no collection effort is made. Each provider makes its own determination in each case as to which patients fall into this category and what kind of collection effort will be made. Because of variations in providers' definitions of bad debt and charity care as well as in accounting procedures, there has been little attempt to distinguish between the two sources of debt—particularly in aggregate data. Thus, studies of uncompensated care generally do not distinguish between nonpayment by the insured and the uninsured. For those most likely not to pay for health care services, these studies do, however, provide information on demographic characteristics, types of illnesses, and costs of services.

Sources of Care for the Uninsured

According to nationally based studies that use data on uncompensated care,[2] the providers of care to the uninsured are most likely to be public and teaching hospitals in metropolitan areas.[3] Compared with the poor insured,[4] the poor uninsured generally use fewer services, receive more free care, and use hospitals as a regular source of care more often.

In metropolitan areas in 1982, uncompensated care, as a percentage of total charges, was 8.6 percent for public hospitals compared with 3.7 percent for voluntary hospitals.[5] When further broken down by teaching and nonteaching status, teaching hospitals with 249 beds or more provided a higher percentage of uncompensated care relative to total charges in both public and voluntary hospitals.[6] For example, the uncompensated care debt (as a percentage of total charges) for teaching public hospitals is 15 percent, compared with 7.2 percent for nonteaching hospitals.

[2]The Urban Institute and AHA jointly conducted A Survey of Medical Care for the Poor and Hospitals' Financial Status in 1980, 1982, and 1984. The surveys were conducted to determine (1) what changes in the amount and distribution of free hospital care had occurred between 1980 and 1984 and (2) how hospitals were reacting to an increasingly competitive environment. Specifically, the surveys were to (1) measure the amount of care hospitals provide to low-income and uninsured individuals; (2) provide data that could clarify the relationship between charity care, bad debt, and a hospital's financial status; and (3) identify early warning signs of hospital financial distress. The 1980 and 1982 surveys are based on samples of 3,000 nonfederal short-term hospitals with 100 or more beds. In addition, a random sample of about 400 smaller hospitals (less than 100 beds) in 1980 and 800 hospitals in 1982 were included. The response rate was about 50 percent for both surveys, and the data reported were based on a maximum of 1,208 private nonprofit and public, nonfederal hospitals that responded to both surveys. This group then formed the sample population for the 1984 survey so that valid comparisons could be made over the 4-year period. Although the 1984 sample is smaller and more select, the response rate was 75 percent, representing about 900 hospitals. The 1984 data have not yet been published.

[3]According to the Association of American Medical Colleges, a teaching hospital is one that is a member of the Council of Teaching Hospitals and has (1) a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education; (2) a letter of recommendation from the dean of the affiliated medical school; (3) at least four approved active residency programs; and (4) at least two of the four residency programs in the following areas—internal medicine, surgery, pediatrics, psychiatry, family practice, or obstetrics and gynecology.

[4]"Poor" is defined in this study as family or individual income at or below the federal poverty level for 1977. "Near poor" is defined as those with income between 101 and 125 percent of the 1977 federal poverty level. For a family of four, "poor" is defined as those families with income at or below $8,000; the category of "near poor" is defined as those with income between $8,000 and $10,000.

[5]A "voluntary hospital" is a private, not-for-profit hospital that is autonomous and self-supporting.

[6]Frank Sloan and others, "Identifying the Issues: A Statistical Profile," in Uncompensated Hospital Care: Defining Rights and Assigning Responsibilities (Vanderbilt University Press, 1986), pp. 9 and 11.

Data from the 1977 NMCES demonstrate that those poor and near poor who are always uninsured use fewer health care services across a variety of utilization measures than those with private insurance, Medicaid, or Medicare. In the categories of prescription drugs, ambulatory nonphysician visits, and hospital stays, the insured poor and near poor use two to three times the number of services as do the uninsured poor and near poor.

An analysis of NMCES data by the National Center for Health Services Research (NCHSR) produced similar results for the working insured and uninsured. Almost 77 percent of the working insured reported at least one physician visit during the year compared with 62 percent of the uninsured. In addition, the working insured are (1) more likely to use prescription drugs (61 percent) than the working uninsured (49 percent) and (2) more than twice as likely to be hospitalized (11 percent) than the uninsured (5 percent).

Precisely why these uninsured use fewer services is not clear. To some extent, they may be in better health and therefore find it unnecessary to use services, or they may be people who need care but are not able to gain access to the care they need. According to a 1986 national telephone survey on access to health care, approximately 16 percent of the sample population reported difficulty in obtaining necessary health services; for almost half of the 16 percent, the barrier was financial.[7]

The 1977 NMCES data also indicate no differences in use of physician services between insured poor and nonpoor. Although the poor and near-poor uninsured use fewer services than the poor and near-poor insured, the uninsured account for a much greater portion of free care. For example, 23 percent of the population covered by private insurance at least part of the time received free ambulatory nonphysician visits compared with 41 percent of those who were always uninsured. Similarly, 12 percent of the uninsured received free hospital care in comparison with 2 percent of the privately insured population.

A number of studies conducted over the past 5 years have established that the uninsured rely more heavily than the rest of the population on hospitals for ambulatory services and as a regular source of care. The research also indicates that reliance on hospital outpatient departments

[7]The Robert Wood Johnson Foundation, Special Report: Access to Health Care in the United States: Results of a 1986 Survey, No. 2 (Princeton, New Jersey: Robert Wood Johnson Foundation Communications Office, 1987), p.5.

and emergency rooms has increased slightly more among the uninsured than among the general population. Between 1976 and 1982, the percentage of uninsured who used hospitals as a regular source of care increased 29 percent; the average in the overall population increased 25 percent.

Types of Medical Bills Incurred by the Uninsured

The medical bills incurred by the uninsured most often involve maternity cases and accidents, as shown in table 4.1.

Table 4.1: Self-Pay and No-Charge Patients by Major Diagnosis

In percent

Diagnostic group	Self-pay/no-charge patients[a]	Estimated charges billed to self-pay/ no-charge patients[b]
Maternity	40	26
Accidents	13	16
Total	**53**	**42**
Digestive disorders	7	9
Mental disorders	6	9
Respiratory disorders	5	6
Circulatory disorders	5	9
Complicated pregnancies	5	2
Genitourinary disorders	5	5
Other	15	19
Total	**48**	**59**

Note: Numbers do not add up to 100 percent because of rounding.

[a]Self-pay and no-charge are used as indicators of uninsured patients.

[b]"Estimated charges" refers to the estimated total dollar amount that the hospital billed to patients for medical services rendered. For example, 26 percent of all hospital charges billed to self-pay and no-charge patients was for maternity care.

Includes infectious and parasitic diseases; neoplasms, endocrine, nutritional, and metabolic diseases; diseases of the blood, blood-forming organs, and musculoskeletal system; congenital anomalies and conditions of the perinatal period; and miscellaneous conditions.

Source: Frank Sloan and others, "Identifying the Issues: A Statistical Profile," in Uncompensated Hospital Care: Defining Rights and Assigning Responsibilities (Vanderbilt University Press, 1986), p. 22. Data are from the 1981 Hospital Discharge Survey conducted by the National Center for Health Statistics.

The uninsured are also most likely to receive care in public and teaching hospitals and have surgery on the day of admission.[5]

[5]Sloan and others, "Identifying the Issues: A Statistical Profile," pp. 12 and 21-26.

Statewide studies and case studies that report data on uncompensated care are often not comparable because of differences in their collection methods and data sources. Three studies, however, presented data on unpaid charges and unresolved bills. In a 1984 statewide study of 21 hospitals in Tennessee, researchers reported that nearly one-half of the charges for the hospitalized uninsured were below $1,000; the mean total charge was $1,505, and the mean unpaid charge was $936.[9] In a case study at Vanderbilt Hospital, the same researchers reported that only 2 to 5 percent of uncompensated care cases involved bills of more than $25,000, but in total these cases accounted for 35 percent of the uncompensated care debt.[10] A statewide study of hospitals in Florida indicated that in 1983, unresolved bills averaged between $1,291 and $2,312,[11] depending on how the data are analyzed.[12] In this study, catastrophic expense cases represented 2 percent of all cases and 16 percent of the total unresolved bills for all respondent hospitals.[13]

A study conducted in 1984 by the California Association of Public Hospitals suggested that patients in public hospitals (who, as discussed above, are more likely to be uninsured) are sicker,[14] typically present more complex and acute health problems, and require multiple medical treatments with more intense services. In addition, transferred patients,

[9]Frank Sloan and others, Analysis of Health Care Options in Tennessee: Uncompensated Care, Final Report (Tennessee: Vanderbilt University, Institute for Public Policy Studies, Health Policy Center, Jan. 1985), p. 46.

[10]Sloan and others, "Identifying the Issues: A Statistical Profile," p. 30.

[11]"Unresolved" in this study refers to the amount a patient is billed minus contractual adjustments and minus the amount received. It is, in essence, the total of bad debt and charity care.

[12]R. Paul Duncan, Jan L. Colbert, and Jane F. Pendergast, State University Study of Indigent Care, Vol. 2: The Analytic Report (University of Florida and Board of Regents, 1986), pp. 2.34-2.95. The 1983 data are presented in a variety of ways, such as unresolved bills by payment source, sex, ethnicity, marital status, source of admission, region of the state, hospital bed size, and hospital ownership. As a result, the average unresolved bill varies according to the variable measured.

[13]The Secretary of Health and Human Services describes catastrophic as ". . . a measure that allows us to identify illness costs that cannot be borne by individuals and families without having to significantly change their life style or drastically modify their expectations of living standards in the future." Catastrophic Illness Expenses (Department of Health and Human Services, Nov. 1986), p. 15.

[14]In 1984, the California Association of Public Hospitals conducted a study of California hospitals to (1) define the special contributions and needs of public and county hospitals and (2) identify policies that would preserve their vital functions. Data were taken from the California Health Facilities Commission; the Office of Statewide Health Planning and Development; and California's Medicaid Program, Medi-Cal. The study also gathered data on its member institutions.

who are generally uninsured,[17] represented less than 2 percent of the uncompensated care cases in the Florida study, but had higher average bills than uncompensated care cases that were not transferred.[18] The transferred patients' uncompensated care debts averaged $2,133, compared with an average of $1,274 for a routine admission.

Paying the Medical Bills of the Uninsured

Health care services provided to the uninsured are paid for directly—out of pocket by the uninsured themselves and by public funds and philanthropy—and indirectly—through cost-shifting to those people with health insurance or the ability to pay. Federal, state, and local funds provide support for indigent patients (that is, those with low income but ineligible for public assistance). Philanthropy, in both public and private hospitals, helps to cover some uncompensated care costs. In addition, hospitals frequently attempt to shift some of the costs from nonpaying to paying patients by raising rates.

Total annual health care expenditures are compared with total annual out-of-pocket expenditures by insurance status for expenditures over $1,500 and over $5,000 (see table 4.2). At both levels of expenditures, the uninsured have lower total health expenditures but higher out-of-pocket costs.

[17] Although there are no national data on transferred patients, case studies indicate that the percentage of patients transferred to public hospitals who were uninsured ranged from 63 percent in Alameda County, California, to 87 percent in Chicago, Illinois. See, for example, GAO, Patient Transfers From Emergency Rooms to D.C. General Hospital (GAO/HRD-87-31, Apr. 30, 1987), p.39; Schiff and others, "Transfers to a Public Hospital: A Prospective Study of 467 Patients," The New England Journal of Medicine, Vol. 314, No. 9 (Feb. 27, 1986), pp. 552-57; and Himmelstein and others, "Patient Transfers: Medical Practice As Social Triage," American Journal of Public Health, Vol. 74, No. 5 (May 1984).

[18] Duncan and others, State University Study of Indigent Care, p. 2.59.

Table 4.2: Comparison of Annual Total Health Care Expenditures With Annual Out-Of-Pocket Expenditures by Insurance Status (1977)

In percent

	Population with annual total health care expenditures[a]			
	Over $1,500		Over $5,000[b]	
Insurance status	Total	Out-of-pocket	Total	Out-of-pocket
No insurance	27	17	9	4
Private	40	11	17	2
Medicaid	49	3	30	1

[a]Numbers are rounded from original data source

[b]Includes expenditures over $1,500

Source: Department of Health and Human Services, Catastrophic Illness Expenses (Nov. 1986), pp. 56-57. Data are from 1977 NMCES aged to 1987.

Using data from the 1977 NMCES, NCHSR demonstrated that although the working insured have higher average expenditures for hospital services ($510, compared with $367 for the working uninsured), in part because the working insured have higher rates of hospitalization, their out-of-pocket expenditures are somewhat lower ($180 compared with $217). NCHSR also reported that among the employed in fair or poor health, the uninsured paid an average of $373 out of pocket annually for their health care; the insured paid $258, a difference of $115. This difference is even more pronounced for those who lose more than 8 days from work (considered a measure of poor health) because of health-related problems. The average annual out-of-pocket expenditure for an insured person in this category is $376; the comparable expenditure for an uninsured person is $638 annually, a difference of $262 (70 percent).[17]

Providing a greater percentage of care than voluntary hospitals to the uninsured, public hospitals are supported primarily by Medicaid (32 percent), state and local non-Medicaid subsidies (28 percent), and Medicare (16 percent). According to studies by GAO and the National Association of Public Hospitals, however, the ability of public hospitals to provide for the increasing number of uninsured has diminished because of (1) reductions in state and federal subsidies for health programs and (2) the limited ability of counties to increase the local tax base.

Private hospitals also bear a substantial burden of uncompensated care. For example, in 1983, private facilities in California absorbed almost

[17]Monheit and others, "The Employed Uninsured and the Role of Public Policy," Inquiry, Vol. 22, p. 31.

$600 million in bad debt and charity care.[14] Although private institutions treat proportionally fewer uninsured than public institutions, private institutions compose 95 percent of the hospitals and 88 percent of the beds. As a result, the aggregate private sector contribution to uncompensated care is considerable.

Analysis of Research Limitations

Although much information is available to answer the questions of where the uninsured obtain care, the types of medical bills they incur, and who pays those bills, the data have limitations that render the picture of health care services for the uninsured incomplete. These limitations include (1) exclusion of certain types of information, (2) use of indirect (proxy) measures to determine the cost and delivery of services to the uninsured, (3) use of different target groups and lack of comparable data, and (4) use of old data. An incomplete picture of these limitations makes developing solutions more difficult.

Current data collection efforts involve only the uninsured who obtain health services. For these uninsured, little data exist on outpatient or physician care; no data exist for those who do not gain entry to the health care system. Data on the working uninsured population are sparse. Most of the available data are case studies that may not reflect the national situation. Further, the uninsured population are a heterogeneous group of people. Their demographic characteristics and their health needs, as well as risks, vary.

Data on medical bills for the uninsured are obtained indirectly by using indicators of uncompensated care, for example, the "self-pay" category of hospital discharge data. Only a few studies have attempted to distinguish between the categories of "bad debt" and "charity care," so little is known about the extent to which uncompensated care is a function of lack of insurance, high copayments and deductibles, or lack of stop-loss coverage.[15]

The data used to address these questions come from studies that address a broad range of issues, including those on uncompensated care, access to health care, and utilization of health care services. Frequently,

[14]Carol B. Emmot, "Health Care for the Poor—A Beneficiary or Victim of Health Cost Containment" (Speech to the Puget Sound Health Service Agency's Conference on Innovations and Alliances, Sept. 20-21, 1984), p. 4.

[15]Stop-loss coverage is a provision that limits the amount the insured may be liable for under cost-sharing, including deductibles and coinsurance.

the studies draw their target groups from different populations so that the data are not always comparable. In addition, the available data are primarily descriptive rather than explanatory; for example, data are available on (1) those who experience financial barriers to medical care or (2) the differences in health care utilization rates between insured and uninsured patients; we do not, however, know why these differences exist or what they mean.

Finally, much of the data available to answer the questions posed in this chapter are based on NMCES, a study conducted 10 years ago. The age of this study poses a major limitation because so many changes in the financing and delivery of health services have occurred since NMCES was done. Until the new data from the updated National Medical Expenditures Survey (NMES) are released (anticipated in 1989), however, NMCES is still the best available source of national data on health care utilization and expenditures.

Policy Options for Providing Health Care Insurance to the Uninsured

As discussed earlier, the uninsured are a heterogeneous group, varying in age, income, and employment. Most approaches for providing health insurance to the uninsured deal with only one segment of the uninsured population; few provide estimates of the costs to implement the proposals or evaluate their effects on other segments of the population. Three broad courses of action are available: leave the situation as it is, restructure the current system, or use a step-by-step approach.

Leaving the situation as it is would not be a cost-free course of action. Through a variety of government health care delivery programs and ad hoc health care financing mechanisms, society is currently paying for most of the health care provided to the uninsured. These costs are typically passed on to others in the form of higher hospital charges, insurance premiums, and taxes.

In the late 1970's a number of approaches were put forth to restructure the health care financing system in the United States. One such approach, called the Consumer Choice Health Plan (CCHP), was intended to replace the current system of (1) open-ended tax exclusions for all employer-provided health insurance and (2) Medicaid, which services only some of the poor.[1] CCHP encouraged universal health insurance, independent of job status. Under this proposal, the federal government would use tax credits to subsidize the purchase by the nonpoor of health insurance from qualified plans. These plans would be required to provide a basic list of medical services and catastrophic expense protection,[2] conduct annual open enrollment, and use community rating to set premiums.[3] Since the poor may need a subsidy to ensure their access to a qualified plan, CCHP included vouchers that could be used only towards payment of the premium for one of these plans. CCHP, along with others of its scope proposed during the 1970's, was not, however, adopted.

An alternative to restructuring the system is developing a series of policies designed to fill the gaps step-by-step in the present structure of employment-sponsored insurance for the employed and limited public programs for some of the unemployed. Although the incremental proposals discussed in the literature are many, the most prominent include

[1] Alain Enthoven, Health Plan (Addison-Wesley Publishing Company, 1981).

[2] Enthoven defines "catastrophic protection" as an annual limit on family out-of-pocket outlays, including deductibles, copayments, and (in the case of an indemnity plan) any difference between indemnity payments and the actual cost of services. He suggests $1,500 as a suitable limit.

[3] "Community rating" is defined by Enthoven as charging the same premium to all people in the same actuarial category enrolled for the same benefits in the same geographic area.

mandating employer-sponsored insurance; expanding Medicaid; establishing industry pooling mechanisms, including multiple employer trusts (METs) or Taft-Hartley arrangements; and encouraging a catastrophic illness program for all Americans. Other more limited options have been suggested, including risk pools for the medically uninsurable,[1] as well as 100 percent tax deductions for the purchase of health benefits by the self-employed and unincorporated businesses. Finally, in 1986 the Congress, in an attempt to address the needs of a limited segment of the uninsured, passed title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see p. 50).

Mandated Employer-Sponsored Insurance

The approach of mandated employer-sponsored insurance has received considerable attention lately because of the introduction of the Minimum Health Benefits for All Workers Act of 1987 (S. 1265, 100th Cong.) by Senator Edward Kennedy in May 1987.[2] The bill, as reported, would have required employers to provide employees who work 17-1/2 or more hours a week and their dependents with insurance for hospital care, physician services, diagnostic and screening tests, and prenatal and well-baby care. Employers would have had to pay at least 80 percent of the cost; for employees earning less than $4.19 per hour, however, employers would be required to pay 100 percent. Employers would also have been required to provide protection for catastrophic medical expenses, limiting annual out-of-pocket health care costs to $3,000 per household.

The bill would have created a pooling mechanism intended to cut small business insurance costs. A regional health insurance carrier would be competitively selected and required to offer two indemnity plans and two managed-care plans to small employers in that region.[3] In introducing the legislation, Senator Kennedy stated his belief that the combination of competition and economies of scale could reduce the cost of

[1]A distinction needs to be made between "industry pooling mechanisms" and "risk pools," as we are using the terms. In industry pools, health risks for both standard-risk and high-risk individuals are covered under the same plan. In risk pools, the excess financial risk of covering otherwise uninsurable individuals is spread among all health plans in a particular state.

[2]A companion bill (H.R. 2508) was introduced in the House by Representative Henry Waxman on May 21, 1987.

[3]A "managed-care plan" is defined in the legislation as ". . . a health benefit plan under which items or services must generally be furnished either by—(A) providers having a contractual relationship with the plan; or (B) providers included on a list specified by the plan that consists of a group of providers in a State that is more restricted than all licensed providers in the State."

insurance to small employers, who would be required to participate in the regional pools.[7]

The annual per worker cost to employers for this proposal would average $708 for coverage of individuals and $1,798 for family coverage, as estimated by the Actuarial Research Corporation, using a rating model of health expenditures derived from various data sources, including these: NMCES, the Rand Health Insurance Experiment, and the National Health Expenditures estimates from the Department of Health and Human Services. The first-year total cost of this approach is estimated by the Congressional Budget Office (CBO) to be about $27.1 billion, $21.8 billion in new employer contributions, $3.3 billion in new employee contributions, and $2 billion for new benefits under existing policies.

CBO estimates the bill would require new insurance or insurance from a different source for 51 million people. This would include 23 million—or nearly two-thirds—of those who were previously uncovered. Only individuals employed less than 17-1/2 hours per week (and their families) would continue to be without health insurance. The characteristics of the workers who would be affected by the bill, according to CBO, would be disproportionately employed by small businesses, concentrated in certain industries, and of low income (see table 5.1).

[7] At the request of Senator Kennedy, GAO has obtained data on the underwriting and rate-setting methods of a sample of insurers currently offering coverage to small groups. A report is being prepared.

Table 5.1: Characteristics of Workers Who Would Have Been Affected by H.R. 2508

In percent

Characteristic	Affected workers
All workers	29
Size of business:	
Under 25 employees	58
25-99	37
100-499	26
500-999	21
1,000 or more	19
Industry:	
Agriculture	62
Construction	38
Finance	24
Manufacturing	16
Mining	15
Public administration	13
Retail trade	51
Services:	
Professional	29
Other	47
Transportation	17
Wholesale trade	20
Family income (in 1986 dollars):	
Under $10,000	67
$10,000-$19,999	36
$20,000 and over	25

Source: CBO tabulations of CPS. May 1983, for business size (the most recent available) and March 1987 for industry and family income.

Other experts have suggested alternate approaches, such as allowing employers a deduction for health insurance contributions only if all employees (including part-time and temporary), family members, or both are covered and minimum coverage is offered.

Expansion of Access to Medicaid

The Medicaid program was enacted to provide the poor with access to mainstream health care. Authorized under title XIX of the Social Security Act, Medicaid is jointly financed with state and federal funds. Within broad federal guidelines, each state designs and administers its own

Medicaid program. Consequently, significant interstate variations exist along important program dimensions, including eligibility requirements.[8]

Medicaid's eligibility provisions are among the most complex of all assistance programs. At a minimum, states must cover (1) all categorically needy people receiving cash payments from the Aid to Families With Dependent Children (AFDC) program and (2) most people receiving payments from the Supplemental Security Income (SSI) program. States have the option to provide cash assistance to other groups, such as poor families with unemployed parents or children over 18 years of age who are attending school. If the state extends AFDC coverage to these groups, it must extend Medicaid coverage as well. States not extending AFDC coverage, however, may still elect to offer Medicaid coverage to groups that are not receiving payments (for example, AFDC or SSI) because members of the groups are in institutions. In addition, states can extend Medicaid coverage to the medically needy—those who (1) meet all criteria for the categorically needy, with the exception of income, and (2) have incurred relatively large medical bills.

For those below, at, or above the federal poverty level, options for expanding Medicaid eligibility have been proposed by a number of researchers. These options propose expansion of Medicaid coverage for families with income below the federal poverty level to (1) all children under the age of 18 years living with those families, (2) parents of dependent children in those families, and (3) all adults in those families without dependent children, possibly allowing them to buy Medicaid coverage as they would private insurance. A fourth option proposes expansion of eligibility to all those families at or above the federal poverty level (within 200 percent). According to EBRI, 62 percent of the nonelderly uninsured fall into one of these four groups.[9] Expanding Medicaid to these groups would reduce the uninsured population, 34.8 million, by 21.6 million, as shown in table 5.2.

[8]GAO, Medicaid: Interstate Variations in Benefits and Expenditures (GAO/HRD-87-67BR, May 4, 1987).

[9]EBRI, "Public Policy Options to Expand Health Insurance Coverage Among the Nonelderly Population," Issue Brief 67 (June 1987).

Table 5.2: Expanding Medicaid Eligibility to Families Below, At, or Above the Federal Poverty Level

In millions

Proposed expansion in relation to poverty level for	Family members affected
Families below the poverty level:	
Children	4.3
Parents	2.4
Adults[1]	4.5
Families at or above the poverty level:[2]	
Children, parents, and adults	10.4
Total	**21.6**

[1]Those without dependent children

[2]"Above" is within 200 percent

Source: EBRI, 1987

A bill introduced by Senator John H. Chafee, the MedAmerica Act of 1987 (S. 1139, 100th Cong.), sets forth an expanded Medicaid option. This bill would have given states the option of extending Medicaid coverage to an individual (1) whose family income does not exceed a level established by the state or is below 200 percent of the federal poverty level, (2) who is uninsurable or has exhausted his or her private insurance benefits, or (3) whose employer has 25 or fewer employees and is unable to provide health insurance at a reasonable cost.

The bill would have set an annual premium, linked to a state's average per capita expenditure for Medicaid beneficiaries. The premium would be limited to 3 percent of the adjusted gross income for those with family income between 100 and 200 percent of the federal poverty level. Families with income below the federal poverty level would be exempt from the premium and any copayment other than the premium and copayment imposed on the categorically needy.

In 1983, it was estimated that it would cost about $3 billion to expand Medicaid to the 3.5 to 4 million people in families without a household head in the labor force.[10] In 1986, it was estimated that to expand Medicaid eligibility to all those below the federal poverty level would cost the public sector (state and federal governments) $6.1 billion annually.[11]

[10]Robert Blendon and others, "Health Insurance for the Unemployed and Uninsured," National Journal (May 28, 1983).

[11]Patricia M. Danzon and Frank A. Sloan, Covering the Uninsured: How Much Would It Cost? (Vanderbilt Institute for Public Policy Studies, Nashville: Dec. 1986).

Industry Pooling Mechanisms

Pooling previously unrelated individuals is an often mentioned mechanism for improving access to health insurance. Two types of pooling that have possible wide application are the formation of METs and Taft-Hartley trusts. Proponents claim these types of pools could lower the costs of health insurance and ease the burden on the small employer, providing health insurance benefits that are usually available only to big companies at low cost for the small employer.

METs are group insurance plans in which individual employers (usually in the same or related industries) participate; these employers—brought together by an insurer, agent, broker, or administrator—provide insurance for their employees, under a master contract issued to a trustee under a trust agreement. Taft-Hartley trusts, so-called because they derive from the provisions of section 302 of the Taft-Hartley Act,[12] were developed for unionized workers in industries with high labor turnover (for example, construction); the trusts act as holders of the employees' health and welfare policies. Employers pay into the trusts on the basis of the number of hours an employee worked. Since the trusts are the holders of the health plans, employees do not lose membership in these plans as they move from job to job within the industry. A similar arrangement could be developed for nonunionized employees who change jobs frequently within an industry.

Catastrophic Illness Programs

Catastrophic illness programs differ in scope and benefits, but their common purpose is to protect individuals and families from being ruined financially by very large medical expenses. These programs generally cover all out-of-pocket medical bills in approved categories. Typically, the insured pays a deductible and co-insurance based on income or assets or both. A catastrophic program is essentially a major medical program with a large deductible.[13] Currently, 35 states have this type of medically needy program for Medicaid recipients.

Estimates of the cost to provide catastrophic coverage with a $750 deductible and $1,750 upper limit on out-of-pocket expenditures per person have been developed. Such coverage could be provided to the uninsured at or below 200 percent of the federal poverty level for $6.9

[12] 29 U.S.C. 186 (c) (5).

[13] According to the Health Insurance Association of America, a major medical program provides benefits for most types of medical expenses up to a high maximum benefit. The program gives less consideration to the cost of minor sicknesses and injuries. Typically, the program is used for prolonged sickness, serious accidents involving extensive periods of hospitalization, or confinement with substantial medical expenses.

billion and to all uninsured for $11.4 billion.[14] Under such a catastrophic coverage program, the insured, on average, would pay an estimated 37 percent of the total health costs in any given year.

Other Approaches

Two approaches frequently mentioned to target the medically uninsurable and the self-employed are state risk pools and use of pretax dollars. Each might provide some relief for the targeted group, but would make only limited progress on the overall problem of the uninsured.

According to a GAO report, 15 states have legislation establishing risk pool programs to help the medically uninsurable—those with medical conditions that make them unacceptable risks to private insurers—obtain health insurance protection.[15] Researchers estimate that 1 million to 2 million uninsured cannot obtain insurance because of medical conditions. The six programs that GAO reviewed have assisted a limited number of people. There are, as yet, no (1) conclusive evidence of the effectiveness of risk pools and (2) data that would allow comparisons of risk pools with other mechanisms for financing health care for the uninsured.

These state risk pools provide insurance to medically uninsurable people at rates that are typically 25 to 50 percent higher than standard risk rates. These rates have historically been too low to cover health care costs incurred, and pool deficits have been shared among the health insurance companies in the state. Covered services vary, but usually include a reasonably comprehensive package of health care services.

Another frequently mentioned incentive for employers to offer health benefits is to allow all employers to use pretax dollars to purchase health insurance. The Tax Reform Act of 1986 allows the self-employed to deduct 25 percent of the premiums for their own health insurance plan from adjusted gross income.[16] Two bills introduced in June 1987 would give the self-employed an 80 or 100 percent deduction, such as other businesses are now entitled to.

[14]Danzon and Sloan, Covering the Uninsured.

[15]Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 13, 1988).

[16]Gail Wilensky, "Public, Private Sector Options to Cover Uninsured Workers," Business and Health (Jan. 1987), p. 43.

Title X of COBRA

Title X of COBRA (P.L. 99-272) attempted to fill some of the health insurance gaps that frequently result from changes in employment status. It requires employers with 20 or more employees to offer some terminated employees and their families the option to buy health insurance identical to that provided before they became ineligible.[17] The reasons for ineligibility include employment termination (other than by reason of gross misconduct), reduction in work hours, divorce, legal separation, Medicare entitlement, or a dependent child's reaching the age at which coverage is terminated under the insurance plan. Continuation coverage must be offered to qualified beneficiaries for (1) 18 months for termination or reduction in hours and (2) 36 months for all other qualifying events. Under COBRA, the employer is not required to pay for the extended coverage, and the employee maybe charged up to 102 percent of the premium.

The Notice of Proposed Rulemaking for COBRA was issued on June 15, 1987, by the Treasury Department. Treasury is responsible for implementing the proposed regulations because title X of COBRA required an amendment to the Internal Revenue Code; Treasury therefore held hearings on the proposed regulations. As of December 1988, however, the regulations had not been made final. In the meantime, employers must act in good faith to comply with the proposed regulations.

Limitations of Approaches

In general, although nearly every authority on the subject of the uninsured has an approach to providing health benefits to them, few have estimated the costs of their approaches. And, when estimates are available, in general, no differentiation is made between (1) added costs resulting from increased access to and use of services by the uninsured and (2) costs shifted from other payers.

Currently, health care services provided to the uninsured are being paid primarily through out-of-pocket payments by the uninsured, by public hospitals and clinics, and, to a lesser extent, by private hospitals through uncompensated care. The various approaches would essentially shift part of the burden of paying for such care either to the employer (mandating employer-sponsored health insurance), the state and federal government (Medicaid expansions and catastrophic insurance proposals), insurers and their insureds (risk pools), or employers and the federal government (tax incentives). Thus, the cost of a particular

[17]This provision of COBRA does not affect (1) employers with less than 20 employees and (2) employees who are not eligible to participate in an employer's health insurance plan.

approach must be balanced with the resultant savings to hospitals and other groups.

How the various approaches affect overall health care spending depends largely on the extent to which they improve access to health care services. For example, catastrophic coverage, because of its high deductible, would most likely do little to improve access to routine medical services for the uninsured and would primarily shift the costs of a catastrophic illness from the individual and hospital to the state or federal government. In contrast, by providing comprehensive health insurance to high-risk individuals, risk pools can be expected to result in increased use of routine health services by covered individuals. Risk pools would thus result both in (1) a shifting of costs already being incurred by the individuals and providers and (2) an increase in costs resulting from improved access. Both the new and shifted costs would be paid by insurers (and their insureds) and the state.

The potential effects of the various proposals on health care cost-containment efforts also need to be considered. Overutilization of services is one of the primary factors contributing to rising health care costs. An effective way to reduce overutilization is to give people a financial stake in their health care benefits. As we noted in a 1982 report,

"... the structure of the third party system isolates many consumers from the financial effects of their use of the health care system. Thus, the price of care for many is no longer a significant factor in health care decisions. As a result, consumers desire and health care providers deliver extensive, high quality care even when only marginal value would result." [18]

Clearly, the uninsured currently have a financial stake in their health care utilization as do the providers, both public and private, who must absorb any costs that the uninsured cannot pay. The problem facing policymakers is how to ensure access to needed medical services without encouraging unnecessary utilization. Both the individual and the provider should, in our opinion, continue to have a financial stake in the individual's health care services.

[18] A Primer on Competitive Strategies for Containing Health Care Costs (GAO/HRD-82-92, Sept. 24, 1982).

According to one study, per capita health care expenditures rise as cost-sharing falls;[1] people with 50 percent copayment spent about 33 percent less on medical services than those with full coverage. In addition, full coverage led to more people using services and to more services per user without a commensurate improvement in health status. The challenge facing policymakers is to select a level of cost sharing that will discourage unnecessary utilization of services, but will not deter individuals from obtaining needed care.

Just as individuals may be insulated from the financial effects of their overuse of medical services by third-party coverage, so too are providers insulated through the fee-for-service payment system. Under this system, providers' income is directly tied to the volume of services provided. Although both public and private third-party payers have increasingly turned to health maintenance organizations (HMOs) and other prepaid health plans in an effort to remove the incentive to overuse and overprescribe health care services, employers are increasingly questioning the ability of HMOs to contain health care costs.

In addition to determining how to equitably distribute the costs of providing coverage, policymakers need to consider the economic consequences (that is, effects on employment, economic growth, and competitiveness in foreign markets) that will result from each approach.

The approaches discussed earlier also have more specific limitations. Mandates are an attractive option to some because a large number of the uninsured could be covered; the cost burden would be on the private, not the public, sector; and precedents for mandating benefits exist. To the extent that program costs were passed on as lower wages, fewer jobs, or higher prices for consumer goods, mandating benefits could be a significant burden on employers and, ultimately, employees.

Senator Edward M. Kennedy's proposal to require businesses to provide health benefits to most of their workers and their dependents would not solve the problem for all of the uninsured. The nonworking uninsured would remain uncovered, as would the self-employed and their dependents, as well as those working less than 17-1/2 hours per week.

Medicaid expansion could (1) reduce work disincentives whereby workers earning too much lose all Medicaid support and (2) provide health

[1]Robert Brook and others, The Effect of Coinsurance on the Health of Adults: Results From the Rand Health Insurance Experiment, Rand Corporation (Dec. 1984), p. vii.

insurance to people who earn too much to be eligible for Medicaid but whose income is too low to permit them to put aside enough of their wages to purchase health insurance. On the negative side, some employers might (1) discontinue the insurance they currently sponsor for those workers who are below the federal poverty level or (2) encourage those workers to apply for Medicaid. Finally, expanding Medicaid would need to be mandated for all states before its impact would be felt on a significant portion of the uninsured. Experience has shown that when states are given the option of expanding Medicaid, the poorer states are less likely to respond. For example, 15 states have not extended Medicaid eligibility to the medically needy. The poorer states, however, may believe that they do not have a sufficient tax base to support a major expansion of their Medicaid program. In addition, expansion of the Medicaid program would most likely heighten existing problems with the program, such as limited participation by providers, complex eligibility processes, and ineffective utilization controls.

Because of the high deductible and upper limit on out-of-pocket expenditures (stop-loss coverage), the cost of a catastrophic program could be limited. Since such a program does not take effect until a person has a serious and expensive illness, there would be little incentive to overutilize services for minor episodes of care. On the other hand, the high deductible could be a barrier to access for routine and preventive care. Finally, a catastrophic program alone would still leave some segments of the population at risk for significant out-of-pocket expenditures.

Title X of COBRA does not affect employers with less than 20 employees. These employers are among those most likely not to sponsor health insurance; title X also does not affect employees who do not have access to health insurance through work. Therefore, the COBRA provisions are likely to provide limited relief for the uninsured. Moreover, many of those who are eligible beneficiaries under COBRA may not be able to afford the full cost of the premiums, even at the group rate, because of loss of income caused by terminated employment.

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